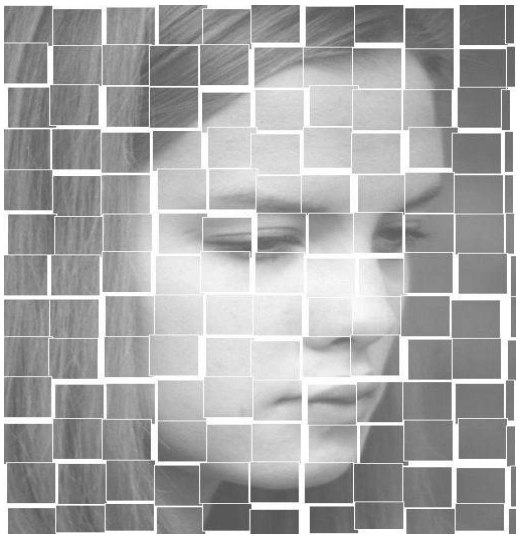
Community Strategies

Preventing Youth Suicide



The Clark County Plan

November 2001

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CLARK COUNTY YOUTH SUICIDE PREVENTION TASK FORCE

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EXECUTIVE SUMMARY

From September 2000 through May 2001, six Clark County youth ages 13 through 16 years took their lives. These tragic events spurred the Board of County Commissioners, with assistance from the Department of Community Services, to convene a task force to develop a community-wide approach for preventing further youth suicides. Community representatives invited to take part in the task force included individuals from local school districts, faith-based organizations, neighborhood and community organizations, medical and health agencies, youth, parent-teacher associations, and County judicial, juvenile justice and social services departments. To provide support to the task force, the Department of Community Services requested assistance from a group of local agencies. These partnering agencies (the Department of Community Services, Southwest Washington Health District and Community Choices 2010) have each prioritized youth suicide prevention as an issue to be addressed.

In order to learn about the issue, the Clark County Youth Suicide Prevention Task Force reviewed the data regarding youth suicide, looked at the approaches the states of Oregon and Washington developed, researched national youth suicide prevention models, heard youths' perspectives, and surveyed the local capacity to address the issue. While the Task Force reviewed data for young people ages 10-24, it was determined that focusing locally on youth in the 10-17 age range would allow for the development of a more effective preventive approach.

After carefully considering the background research, the Task Force developed a set of strategies to guide the community's efforts to prevent youth suicides in the future. These strategies fall into three broad categories, namely public awareness and education, skill building, and access to services. The following strategies do not stand alone, but are linked and need to be implemented simultaneously:

Strategy 1: Develop active community involvement in positive youth development.

Strategy 2: Educate the public about youth suicide.

Strategy 3: Establish media partnerships.

Strategy 4: Develop peer resources through school-based prevention programs.

Strategy 5: Conduct suicide prevention and intervention training for professionals and others who work with youth.

Strategy 6: Improve access to mental health and substance abuse intervention and treatment services.

The successful implementation of these strategies calls for the many organizations involved to work collaboratively. Each strategy has a lead organization designated to take responsibility for ensuring that work moves ahead. In addition, each strategy identifies

collaborating organizations that will assist in the implementation efforts. This approach will help to broaden the community involvement in youth suicide prevention. The Clark County Board of Commissioners, through the Department of Community Services, will oversee the implementation of the Clark County Youth Suicide Prevention Plan.

The Task Force recognizes that the strategies and collaborative efforts called for in this report can make a meaningful difference and prevent future tragedies of youth suicide. However, we would be remiss if we did not state that in order to be truly successful, the entire community must respond to the overwhelming needs of youth, which this day is manifesting itself among us through the tragic events of youth suicide. A caring community can only be created by more adults taking an active role in listening to the voices of our youth, demonstrating support, and participating in caring and supportive relationships. No amount of government funding or collaborative strategies can create what a caring community can accomplish.

INTRODUCTION

BACKGROUND

In the spring of 2001, the Clark County Board of Commissioners elected to convene a task force to address the problem of youth suicide in the county. The impetus for the task force was the deaths by suicide of six young people during the time period September 2000 through May 2001. Commissioner Craig Pridemore, representing the Board of County Commissioners, requested assistance from the Department of Community Services in establishing a task force composed of community stakeholders and professionals.

The Clark County Youth Suicide Prevention Task Force reflected the community's alarm about the deaths of the county's young people and was committed to developing a youth suicide prevention plan for Clark County. The Task Force took as its charge creating a competent community with the knowledge and skills needed to prevent and respond to youth suicide. Available state and national data was reviewed, including data for young people up to age 24. Although suicide rates for young people are highest among 18-24 year-olds, the Task Force focused on 10-17 year-olds in an effort to be prevention-oriented and enhance the community's capacity to build relationships that support youth.

The Task Force met from May through November 2001 and was supported in its work by a staff-level group representing local partnering organizations. These organizations, which include the Clark County Department of Community Services, Community Choices 2010, and the Southwest Washington Health District, have all identified youth suicide prevention as a priority issue.

Research by the Task Force yielded a number of findings that guided the recommendations included in this plan. Most important among these findings were:

- While it is too soon to determine whether or not the suicides of six youth within a nine month period is indicative of a trend over time, it is still a concern for the community. Youth suicide is an issue nation-wide; Clark County is not alone in its goal to prevent youth from taking their own lives. Graph 1 in Appendix A shows the rates of youth suicide for Washington State and Clark County as compared to the national target.

- Review of emergency services contacts from January 2000 through June 2001 revealed that local sheriff and police departments were contacted regarding 107 youth who had attempted or threatened suicide, 12 of them more than once. The hospital emergency department saw 197 youth who had attempted or threatened suicide, and 45 of those youth were seen more than one time for suicide attempts or threats.

- The responses by more than 11,000 Clark County youth to the 1999 Search Institute Developmental Assets Survey revealed that depression, suicide attempts, and drug and alcohol use among the young people is a concern. Seventeen percent of the 10th and 12th grade students indicated having attempted suicide one or more times. Twenty-six percent of the 10th and 12th grade students reported being frequently depressed and/or having attempted suicide. In addition, 43% of the 12th grade students reported using alcohol one or more times in the last 30 days. Twenty-four percent of the 10th and 30% of the 12th grade students reported having used illicit drugs three or more times in the past 12months. (See Table 5 and Graphs 8, 9 and 10 in Appendix A.)

- Youth participating in focus groups were clear in sharing their perspectives on issues related to youth suicide. In particular, youth stressed their belief in their ability to play a central role in youth suicide prevention. They believe that their peers will turn to other youth for help before seeking assistance from adults. Youth also shared their concern that they are not currently viewed as valued members of the community and that this causes them to feel alienated.

- Local capacity to effectively prevent youth suicide and intervene appropriately is presently limited. Key elements of an effective youth suicide prevention and intervention model are not in place: the community does not have a complete understanding of the issue; school prevention programs are limited; treatment for mental health and substance abuse problems can be difficult to access; and the tracking of information about youth suicide deaths is not coordinated among service providers. (See Table 6 and Figure A-1 in Appendix A.)

- National research suggests best practices for laying a strong foundation for local youth suicide prevention efforts. Included in the research are the models put forth by the United States Surgeon General and the states of Washington and Oregon. These approaches offer strategies that do the following:
  - Build a strong community understanding of youth suicide prevention;
  - Develop specific prevention capacity involving schools and youth;
  - Ensure that treatment for mental health and substance abuse problems are available in the community; and
  - Provide for ongoing evaluation of efforts and tracking of data to monitor the community's effectiveness in responding to the issue.

MODELS IN YOUTH SUICIDE PREVENTION

Three youth suicide prevention models served as reference points in the development of this plan. The 1995 Youth Suicide Prevention Plan for Washington State (the "Washington Plan"), the 2000 Oregon Plan For Youth Suicide Prevention: A Call to Action (the "Oregon Plan"), and the U. S. Surgeon General's Call to Action to Prevent Suicide (the "Surgeon

General's report") all present community-wide strategies grounded in evidence-based, comprehensive approaches.

Washington has become a recognized leader in state-developed strategies to prevent and respond to youth suicide. Washington was the first state to develop such a plan, and other states that have subsequently developed youth suicide prevention plans have taken the Washington Plan as their model.

The Oregon Plan provided an additional perspective, since Clark County is part of the Portland Metropolitan Area. The approaches recommended in the Oregon Plan are applicable to Clark County as well.

The Washington and Oregon plans both closely parallel many of the recommendations contained in the Surgeon General's report as shown in Table 1.

TABLE 1.

U.S. Surgeon General's Call To Action To Prevent Suicide NATIONAL STRATEGY FOR SUICIDE PREVENTION: GOALS FOR ACTION
Goal 1: Promote awareness that suicide is a public health problem that is preventable
Goal 2: Develop broad-based support for suicide prevention
Goal 3: Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse, and suicide prevention services
Goal 4: Develop and implement suicide prevention programs
Goal 5: Promote efforts to reduce access to lethal means and methods of self-harm
Goal 6: Implement training for recognition of at-risk behavior and delivery of effective treatment
Goal 7: Develop and promote effective clinical and professional practices
Goal 8: Improve access to and community linkages with mental health and substance abuse services
Goal 9: Improve reporting and portrayals of suicidal behavior, mental illness, and substance abuse in the entertainment and news media
Goal 10: Promote and support research on suicide and suicide prevention
Goal 11: Improve and expand surveillance systems

Source: U.S. Public Health Service, "The Surgeon General's Call to Action to Prevent Suicide," http://www.mentalhealth.org/suicideprevention/strategy.asp.

The Washington Plan adopted a three-tiered approach to youth suicide prevention. The approach developed by the Institute of Medicine in 1994 is comprised of universal, selective, and indicated strategies. Universal strategies encompass broad-based activities reaching 85 percent or more of the population. Examples of universal strategies are public education campaigns, school-based education campaigns, public education campaigns to

restrict access to lethal means of suicide (e.g., firearms, drugs), and education about youth suicide for members of the media.

The goal of selective strategies is to identify those youth that demonstrate suicidal tendencies or behaviors and provide services they need. Approximately 25-30 percent of all youth fall into this group. Selective strategies include screening programs (e.g., screening for substance abuse, depression, other mental health issues), training for "gatekeepers" (i.e., those youth, parents, and professionals who have regular contact with youth), and crisis intervention services (e.g., crisis hotlines, substance abuse treatment, mental health treatment).

Indicated strategies are those focusing on youth at high risk of attempting suicide. These might be youth who have made a previous attempt or who have demonstrated clear suicidal tendencies. Approximately 10-15 percent of all youth are expected to fall into this group. Strategies for serving these youth include:

- Skill-building and social support services for youth (e.g., life skills training, anger management);
- Family support training to help families better understand
  - youth suicide
  - behaviors their child is exhibiting
  - knowledge and skills needed to better support their child.

To these three strategy areas, the Washington Plan adds a fourth component: evaluation and surveillance. The state of knowledge about best practices in youth suicide prevention is still in its infancy. Little research-based information is available that recommends one strategy over another. As a recent article relating to youth suicide states, "Because few suicide prevention strategies have been evaluated, the effectiveness of suicide prevention programs has not been demonstrated."[1]

The framework described above, however, aims at creating a safety net for youth and building the skills needed to ensure community competence in preventing and responding to youth suicide. Through evaluation and data tracking activities, the goal is to increase knowledge about suicidal behaviors and to build a common understanding about what works in youth suicide prevention.

The Task Force adopted this model to guide its work, with slight modifications. The Clark County Youth Suicide Prevention Plan refers to "targeted strategies" in the place of "selective strategies" and "intensive strategies" instead of "indicated strategies." "Evaluation and data tracking" replaces the term "evaluation and surveillance." The set of activities within each

[1] Iris Wagman Borowsky, Marjorie Ireland, and Michael D. Resnick, "Adolescent Suicide Attempts: Risks and Protectors," Pediatrics, 107:3 (March 2001), p. 491.

approach, however, remains constant. Priority areas in the Clark County Youth Suicide Prevention Plan focus especially on universal and targeted strategies.

ISSUES IN YOUTH SUICIDE PREVENTION

The circumstances and events that lead a young person to attempt suicide are complex and distinctly individual. While it may be difficult to predict if a youth will attempt suicide, there are indicators and issues that play a key role in understanding a young person's response to his or her life events.

BUILDING COMMUNITY CAPACITY

As a community we are faced with a difficult but necessary challenge: to effectively provide individual support for youth from very early on in their lives. Young people need to be seen for who they are as individuals, important to the entire community. Adults need to be present in young people's lives; relationship is key to providing support for youth. This concept is an underlying factor connecting all the strategies in this report.

SUICIDAL RISK

There are clear indicators of suicidal risk. The relationship between risk and protective factors for individual youth can suggest the degree of risk. Risk factors can include such things as poverty, drug and alcohol use, criminal activity, school truancy, untreated depression or other mental health issues, and isolation from peers. Protective factors include strong family and community support, engagement in community activities, a sense of self-esteem and self-worth, and strong school performance.

Other factors place youth at risk as well. Females are more likely to attempt suicide, but males are four times more likely to complete a suicide because of their tendency to use more lethal means of self-harm. Experts have also determined that the most significant indicator of suicidal risk is a previous attempt. These youth require immediate and ongoing intervention. In addition, national data indicates that gay and lesbian youth are at increased risk of suicidal behavior, accounting for up to 30 percent of youth suicides annually.[2]

LACK OF PUBLIC AWARENESS

The lack of public awareness of suicidal risk factors, signs of depression, and resources for intervention are significant challenges in youth suicide prevention. Parents often conclude that the behaviors exhibited by youth are "just part of being a teenager." Alternatively, they may suspect a problem but not know how to respond or where to get help. Peers, who youth are more likely to confide in than parents, school counselors, or other professionals, also have little knowledge of risk behaviors and how to respond appropriately to a friend in need. Without a general understanding of risk factors, parents, youth, and other community

[2] Borowsky, Ireland, and Resnick, "Adolescent Suicide Attempts," p. 490.

members are less likely to intervene, with the result being that many youth who attempt or commit suicide never gain access to needed services. A lack of understanding of youth suicide and failure to follow nationally-recommended media guidelines on reporting the issue can also lead members of the media to unintentionally contribute to a "contagion" effect of "copy cat" or cluster suicides.

STIGMA

The stigma associated with youth suicide, mental health services, and substance abuse treatment is an additional challenge. As noted in the Surgeon General's report, "The stigma of suicide itself – the view that suicide is shameful and/or sinful – is also a barrier to treatment for persons who have suicidal thoughts or who have attempted suicide. Family members of suicide attempters often hide the behavior from friends and relatives, and those who have survived the suicide of a loved one suffer not only grief of loss but often the added pain stemming from stigma."[3] When youth and their families do seek help, they confront the stigma associated with mental health and substance abuse treatment. Reducing the prevalence of such perceptions can be an important step in helping youth to access prevention services.

TRAINING

It has become clear that training for those coming in regular contact with youth is an important consideration. Many health professionals and social workers may receive little or no specific training in youth suicide prevention and response. According to the Surgeon General's report, "Studies indicate that many health professionals are not adequately trained to provide proper assessment, treatment, and management of suicidal patients, nor do they know how to refer clients properly for specialized assessment and treatment."[4]

When training programs are successfully implemented, studies have found that they can be effective in reducing youth suicide. For instance, "Studies show that [juvenile correctional and detention] facilities that conduct suicide screening at admission and that train staff in suicide prevention have lower rates of suicidal behavior. Detention facilities that have a lower staff to youth ratio [also] had lower suicidal behavior rates. Facilities with high staff turnover rates had increased rates of suicidal behavior, which underscores the importance of staff training in suicide prevention."[5]

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[3] "National Strategy for Suicide Prevention," p. 3.

[4] "National Strategy for Suicide Prevention: Summary," http://www.mentalhealth.org/publications/allpubs/SMA01-3518/index.htm, p. 5.

[5] Governor's Juvenile Justice Advisory Committee, "2000 Juvenile Justice Report," Office of Juvenile Justice, Olympia, Washington, p. 91.

ACCESS TO SERVICES

For those youth who do seek help and attempt to access services, the obstacles can be great. Issues around insurance coverage for mental health treatment and limited professional expertise in working with suicidal youth mean that, even when troubled youth seek help, it may not be readily available.

DATA TRACKING

Youth suicide attempts may be significantly underreported. Those who receive emergency medical services for an attempt may not be consistently recorded, and 911 records only measure those attempts that result in a call to 911. In addition, there is little coordination among the organizations tracking youth suicide; compiling a complete picture of youth suicide requires gathering and analyzing data from hospitals, police jurisdictions, fire departments, crisis lines, coroner or medical examiner offices and others. To date no one organization has taken responsibility for preparing this complete picture.

STRATEGY 1:

DEVELOP ACTIVE COMMUNITY INVOLVEMENT IN POSITIVE YOUTH DEVELOPMENT

IMPLEMENTATION LEADER

Clark County Department of Community Services

With assistance from the Southwest Washington Health District, Community Choices 2010, local community organizations, faith-based organizations, other local municipalities, neighborhood associations, and the YMCA.

OBJECTIVE

- Increase the number of youth who have a supportive relationship with at least one caring adult;
- Increase community awareness of ways to support positive youth development; and
- Increase community participation in activities that support youth.

AUDIENCE

General public.

RATIONALE AND EFFICACY

The 1999 Developmental Assets Survey revealed that many Clark County youth feel that they are not valued by adults and do not feel that they play a central role in community life. A feeling of isolation from adults and community is one of the factors known to contribute to high-risk behaviors such as alcohol and drug abuse, juvenile crime, and poor school performance.

Reversing these perceptions of youth requires that:

- The community intentionally focuses on ways adults can build relationships with youth;
- Clark County adults make individual efforts to connect with and mentor youth;

- Clark County residents are educated about the importance of building developmental assets among youth; and
- The community invests more time and resources in its youth.

IMPLEMENTATION CONSIDERATIONS

- Improving the relationship between youth and adults requires a greater degree of engagement in and more time devoted to community life.

IMPLEMENTATION ACTION STEPS

	TO BE COMPLETED BY
1. Identify programs that bring together and build relationships between youth and adults	March 2002
▪ Advocate for programs that enhance youth development	
2. Encourage local media to continue to highlight positive youth attributes	March 2002
3. Develop a social marketing campaign to inform the community about the positive contribution of youth to community life	January to June 2002
4. Conduct community training events	March, June and October 2002

AVAILABLE RESOURCES

- A number of mentoring programs already exist in the community, but need to be expanded and supported more aggressively.
- There are community-based youth organizations interested in leading education efforts.
- Resources are available through the State of Washington to conduct training about developmental assets.

RESOURCES NEEDED ANNUALLY

Campaign support	$10,000

This strategy will be funded with existing resources, which may require reprioritization of current programs and staffing. Resources will need to be identified in the current biennium.

Strategy 2:
EDUCATE THE PUBLIC ABOUT YOUTH SUICIDE

IMPLEMENTATION LEADER

Southwest Washington Health District

With assistance from Clark County Department of Community Services, Southwest Washington Medical Center, neighborhood associations, and community mental health centers.

OBJECTIVE

- Increase community awareness of suicide warning signs;
- Increase community awareness of available youth suicide-related resources; and
- Increase community competence to identify and respond effectively to youth at risk for suicide.
    - Youth and adults will be able to "ask the question, show you care, and refer to resources".

AUDIENCE

General public, including parents, youth, school personnel, and neighbors.

RATIONALE AND EFFICACY

Public education campaigns about the warning signs of depression and youth suicide risk have not previously been implemented in Clark County. The level of community competence in preventing youth suicide needs to be improved. By working "upstream," educating Clark County residents about the signs of depression and suicide risk, youth will be more likely to get the help they need as soon as possible and before a crisis arises.

IMPLEMENTATION CONSIDERATIONS

- Increased public awareness and understanding of youth suicide prevention may increase the need for related mental health and substance abuse services.
- Public education efforts require time and money to sustain.
- Competing news events make it difficult to focus attention on a specific issue.
- Local "champions" are needed to spearhead public education efforts.

IMPLEMENTATION ACTION STEPS

	TO BE COMPLETED BY
1. Identify existing curriculum to train community groups, including county agencies and youth groups, to design and implement public education campaigns	February 2002
▪ Sponsor first training	March 2002
▪ Conduct train-the-trainer sessions	April 2002
2. Develop a public education campaign (identify target audiences and messages)	March 2002
▪ Identify and/or develop a fact sheet for distribution in the community	
3. Conduct school and community-based events to teach parents and other adults about the warning signs of youth suicide	March 2002
▪ Convene a public education design group involving school district staff, parents, and other adults	
▪ Sponsor first public education event	June 2002
4. Ensure broadcast of youth suicide prevention public service announcements on local television and radio stations	May and September 2002
5. Organize youth-led training events and outreach efforts	June 2002
▪ Sponsor first event	

AVAILABLE RESOURCES

- Peer support programs.
- Public service announcements, trainer materials, and public education materials are available through Washington State and youth suicide prevention organizations.
- Nationally-sponsored depression screening days.
- Parent Teacher Organizations (PTO)/ Parent Teacher Associations (PTA).
- Local youth organizations.
- Communication Specialists/Public Information Officers with involved organizations, e.g. Clark County Department of Community Services, Southwest Washington Health District.

RESOURCES NEEDED ANNUALLY

1.5 FTE Staff	$80,000
Campaign budget	$30,000

This strategy will be funded with existing resources, which may require reprioritization of current programs and staffing. Resources will need to be identified in the current biennium.

Strategy 3:
ESTABLISH MEDIA PARTNERSHIPS

IMPLEMENTATION LEADER

Southwest Washington Health District

With assistance from the Clark County Department of Community Services, Community Choices 2010, and public information officers at the Southwest Washington Medical Center, neighborhood associations, PTA/PTOs.

OBJECTIVE

- Local media abide by the Centers for Disease Control (CDC) reporting guidelines in youth suicide coverage; and
- Local media assist the community in preventing youth suicide by publicizing known prevention strategies and/or prevention-related events.

AUDIENCE

Media organizations; general public.

RATIONALE AND EFFICACY

The media can play a powerful role in educating the public about suicide prevention. Stories can inform readers and viewers about the likely causes of suicide, its warning signs, trends in suicide rates, and recent treatment advances. Implementation of established reporting guidelines for media coverage has been shown to decrease suicide rates. (Barraclough, B., and Houghes, J., 1987, Suicide: Clinical and epidemiological studies. London: Croom Helm.)

IMPLEMENTATION CONSIDERATIONS

- The complexity of youth suicide may make members of the media reluctant to tackle the issue. Some may fear exacerbating the problem by reporting on it.
- There are local community members, including youth and suicide survivors, willing to work with media about the role media can play in educating the public about issues contributing to youth suicide risk.

IMPLEMENTATION ACTION STEPS

	TO BE COMPLETED BY
1. Enlist the leadership of Clark County and Portland-based newspaper, radio, and television as partners in preventing youth suicide	February 2002
▪ Determine which newspapers, television, and radio stations have adopted a policy to adhere to CDC youth suicide prevention reporting guidelines	
▪ Hold meetings with the leadership of newspaper, radio, and television stations to encourage their use of the CDC guidelines and to offer training and other assistance to media staff	March 2002
2. Enlist the support of the public information officers at the school districts and the Educational Service District as partners in youth suicide prevention	February 2002
3. Define an effective and appropriate role for school, neighborhood and community newspapers/newsletters to play in youth suicide prevention	April 2002

AVAILABLE RESOURCES

- Media guidelines are readily available at no cost.
- Public service announcements are available through state and national sources.

RESOURCES NEEDED ANNUALLY

1.5 FTE Staff $80,000

This strategy will be funded with existing resources, which may require reprioritization of current programs and staffing. Resources will need to be identified in the current biennium.

Strategy 4:
DEVELOP PEER RESOURCES THROUGH SCHOOL-BASED PREVENTION CAMPAIGNS

IMPLEMENTATION LEADER

Clark County Department of Community Services

With assistance from the Educational Service District, Clark County school district superintendents, and PTA/PTOs.

OBJECTIVE

- All school districts in Clark County endorse and adopt a standardized youth suicide prevention program in order to:
  - Provide youth with support and assistance from trained peers
  - Increase the likelihood that local schools will be prepared to effectively address the issues of youth depression, drug and alcohol use, and other concerns that contribute to youth suicide.

AUDIENCE

Youth in Clark County schools; teachers and school personnel.

RATIONALE AND EFFICACY

Focus group findings demonstrate that youth are most likely to turn to their peers in times of need. Yet youth often do not know how to respond or how best to help their friends. While they can be a conduit for providing help, peers cannot be expected to be service providers. Young people need to know what to do when a friend has a problem.

School-based campaigns led by students have been implemented in other pilot sites in Washington through the Washington State Youth Suicide Prevention Program. Evaluations of these campaigns showed them to be an effective tool providing students with a direct role in prevention efforts – a role that they welcome – and increasing awareness of suicide warning signs and resources.

IMPLEMENTATION CONSIDERATIONS

- The success of the strategy will require the active support of parents and community members.

- This strategy is directly linked to both Strategy 2 (Educate the Public About Youth Suicide) and Strategy 6 (Improve Access to Mental Health and Substance Abuse Intervention and Treatment Services). Adults and youth need to know what questions to ask when they are concerned about a young person and what number or numbers to call. Service providers are instrumental in making sure a young person has access to services when requested.
- Discussing youth suicide within the school environment requires a balance between the need to educate and train and the need to sensitively deal with what is often seen as a "taboo" subject.

IMPLEMENTATION ACTION STEPS

	TO BE COMPLETED
1. Explore how prevention programs successfully develop partnership with schools	March 2002
2. Identify youth suicide-related resources or activities currently available in the schools	March 2002
3. Obtain more information about school-based prevention campaign models	March 2002
4. Identify resources needed to implement school-based prevention campaigns	June 2002
5. Develop support from school districts for implementing school-based prevention campaigns	June 2002
▪ Identify a contact person in each district who can coordinate a school-based prevention campaign	
6. Begin implementation of the school-based prevention campaigns	September 2002
7. Work with school districts to establish suicide response plans (crisis teams, etc.)	September 2002
8. Evaluate the campaigns	January to December 2003

AVAILABLE RESOURCES

- Training resources and materials are available locally.

RESOURCES NEEDED ANNUALLY

This strategy can be implemented as part of the current and ongoing efforts already provided by local organizations.

Strategy 5:

CONDUCT SUICIDE PREVENTION AND INTERVENTION TRAINING FOR PROFESSIONALS AND OTHERS WHO WORK WITH YOUTH

IMPLEMENTATION LEADER

Clark County Department of Community Services

With assistance from the Southwest Washington Health District, Community Choices 2010, Southwest Washington Medical Center, and the State of Washington.

OBJECTIVE

- Increase the skill and understanding about youth suicide prevention for community members who work with youth; and
- Increase the ability of professionals and others who work with youth to intervene appropriately.

AUDIENCE

Professionals and other community members who work with youth (e.g., mental health treatment providers, substance abuse treatment providers, youth pastors, youth leaders, school counselors, etc.).

RATIONALE AND EFFICACY

Adults play an important role in supporting youth, whether in professional or non-professional positions. In order for youth to feel comfortable seeking help from adults, adults need to learn appropriate/effective ways to address the issue of suicide.

Focus group and key informant findings reveal that many professionals and others who work with youth may not always respond effectively to youth in crisis.

Training is needed to ensure that all those who work with youth are proficient in recognizing the signs of suicide risk among youth and intervening appropriately.

IMPLEMENTATION CONSIDERATIONS

- Resource constraints exist across systems, and emphasis is often placed on the crisis component of systems rather than on prevention services.
- Different groups will require varying approaches to training and engagement.
- Professionals and others working with youth will need to be convinced of the need for and value of standardized training in order to ensure that a strong safety net exists for youth.

IMPLEMENTATION ACTION STEPS

	TO BE COMPLETED BY
1. Identify "gatekeepers" (youth and adults) who have been trained in youth suicide prevention and intervention	April 2002
▪ Assess where more gatekeepers are needed	
2. Implement gatekeeper training with a focus on community members who work with youth	September 2002
▪ Identify individuals and community groups to recruit for participation in gatekeeper training (e.g., parents, foster parents, faith-based organizations, youth organizations, prevention specialists, mentors, coaches of youth leagues, fast food managers, theater managers, etc.)	
▪ Develop a training strategy for each group	
3. Identify training opportunities for professionals who work with youth, including teachers, counselors, school nurses, pediatricians, internists, family practitioners, emergency room staff, medical office staff, mental health practitioners, etc.	February 2003
▪ Meet with school districts to discuss the use of in-service days for youth suicide training (linked to school-based prevention campaign discussion)	

AVAILABLE RESOURCES

- Gatekeeper training is currently available through the Washington State Suicide Prevention Program and affiliated certified trainers.

RESOURCES NEEDED ANNUALLY

Gatekeeper training	$2,500/training
School release time coverage	$5,000
Specialized professional training	$5,000

This strategy will be funded with existing resources, which may require reprioritization of current programs and staffing. Resources will need to be identified in the current biennium.

STRATEGY 6:

IMPROVE ACCESS TO MENTAL HEALTH AND SUBSTANCE ABUSE INTERVENTION AND TREATMENT SERVICES

IMPLEMENTATION LEADER

Clark County Department of Community Services

With assistance from the Washington State Division of Children and Family Services, Juvenile Court, Southwest Washington Medial Center, and community mental health service providers.

OBJECTIVE

- Increase the number of youth who receive mental health and substance abuse services;
- Improve the timeliness of the mental health and substance abuse services provided to youth; and
- Improve the effectiveness of the mental health and substance abuse services provided to youth.

AUDIENCE

Mental health and substance abuse service providers.

RATIONALE AND EFFICACY

Substance abuse and mental health issues, such as depression, are known factors contributing to suicide risk. As public education efforts increase community awareness about effective responses to youth suicide risk and available resources, access to those resources, particularly mental health and substance abuse services, will become critical.

Information from focus group participants indicates a perception that access to services is limited. Services may be restricted to people who meet specific eligibility criteria, and capacity often does not meet demand. Within the private sector, insurance benefits for treatment may be limited and services for youth are often difficult to obtain.

There is a stigma surrounding mental health and substance abuse treatment that often prevents those in need from seeking services.

IMPLEMENTATION CONSIDERATIONS

- Overcoming the stigma associated with mental health and substance abuse treatment will be a particular challenge.
- Limited resources and the constraints of the managed care system present obstacles to expanding access to services.

IMPLEMENTATION ACTION STEPS

	TO BE COMPLETED BY
1. Convene a work group to explore methods to increase access to mental health and substance abuse intervention and treatment	March 2002
2. Develop a "warm" phone line staffed by trained peers as a tool to connect youth to appropriate services	September 2002

AVAILABLE RESOURCES

- Training opportunities aimed at improving the ability of professionals working in crisis services to appropriately refer and serve youth currently exist.
- Mental health services staff at Clark County Department of Community Services are also available to assist in these efforts.

RESOURCES NEEDED ANNUALLY

"Warm Line" costs	$35,000
Monitoring/tracking progress	$15,000

This strategy will be funded with existing resources, which may require reprioritization of current programs and staffing. Resources will need to be identified in the current biennium.

TABLE 2.

SUMMARY OF RESOURCES NEEDED ANNUALLY

$160,000	3 FTE
$30,000	Public Awareness Campaign
$10,000	Social Marketing Campaign
$12,000	Training
$50,000	Warm line and data monitoring
$262,500	Total

If additional state and/or local resources are not available, the participating organizations will need to reprioritize current programs and staffing.

APPENDIX A: CLARK COUNTY DATA

To achieve its goal of creating a competent community capable of preventing youth suicide in Clark County, the Task Force first initiated an extensive data collection effort to better understand the nature of youth suicide in Clark County. Data collection efforts included:

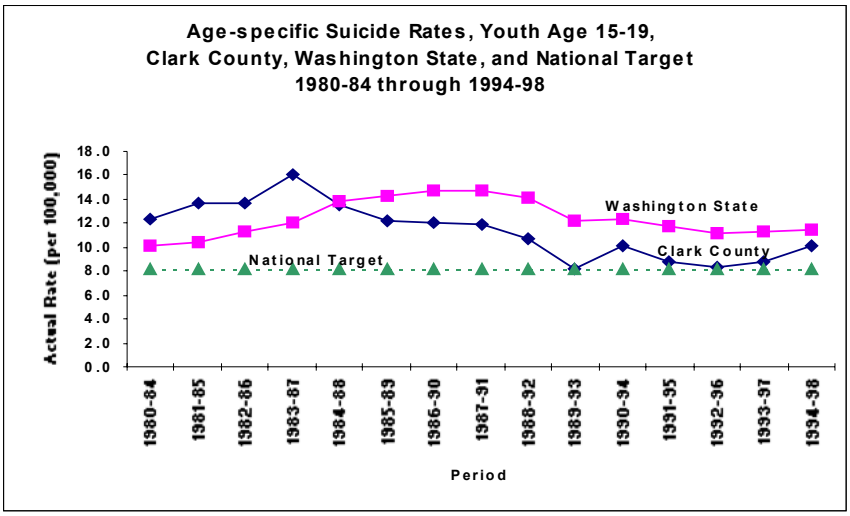
- Collecting and reviewing local data from emergency and crisis services (911, sheriff/ police, emergency department, and crisis mental health) related to youth suicide.
- A review of available epidemiological data from Washington State and Clark County;
- A review of results of the Search Institute's Developmental Assets Survey administered to 6th, 8th, 10th and 12th grade youth in Clark County, 1999.
- Focus groups and key informant interviews with parents, teachers/school personnel, and youth; and
- A capacity mapping effort to ascertain current resource and service availability for youth suicide prevention and response in Clark County.

The analysis of the data collected supported the strategy development for this plan.

EPIDEMIOLOGICAL DATA

Careful epidemiological analysis revealed that the pattern of youth suicides experienced in Clark County from September 2000 through May 2001 may be a random variation and not necessarily indicative of a significant change in the magnitude of youth suicide within the county. Nationally the rate of suicide for youth 15-19 years was 8.2 per 100,000 in 1999.[6] Graph 1 below shows the suicide rate in Clark County and Washington State, compared to the national target.

GRAPH 1



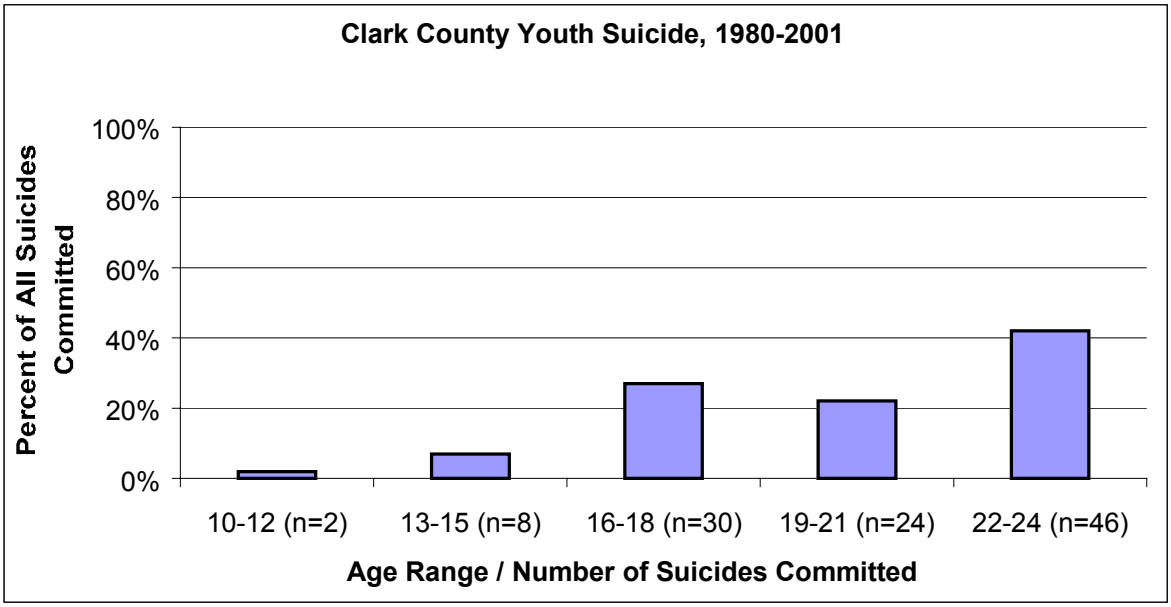
Source: Washington State Department of Health, Center for Health Statistics.

[6] (National Center for Health Statistics, www.cdc.gov/nchs/datawh/statab/unpubd/mortabs/gmwk292a_10.htm)

The data show the youth suicide rate in Clark County and Washington State to be higher than the 1999 national rate, and higher than the national target for close to twenty years.

Most deaths to young people are from injuries as opposed to disease. The overwhelming majority of youth deaths are from accidents, including motor vehicle injuries. Second after accidents, though far fewer in number, suicide also claims the lives of youth aged 10-17. As with other injuries, suicide is considered a preventable cause of death.[7] Over a longer timeframe, suicide deaths among Clark County residents between the ages of 10 and 24 from 1980 through the first quarter of 2001 were as follows:

GRAPH 2: YOUTH SUICIDE



Source: Washington State Department of Health, Center for Health Statistics, March 2001 and the *2000-2001 Clark County Infant and Child Death Review*, March 2001

In keeping with national statistics, more Clark County males than females between the ages of 10 and 24 died from suicide between 1980 and 2001. Among youth under the age of 18, the ratios in death by suicide between males and females in Clark County was relatively close during this period, with males generally having a slightly higher incidence of suicide. After the age of 18, however, the ratio between male and female suicide completion rates increased, with males at significantly greater risk.

[7] The causes of death reported in this document are based on the International Classification of Diseases, Ninth Revision (ICD-9), published by the World Health Organization (WHO) and used in the U.S. since 1979.

Research has shown that substance abuse problems are often associated with suicide attempts and suicidal ideation. A 1991 report found that, according to hospital emergency room data from major metropolitan areas, "over 60 percent of 10- to-17- year-old's drug-related encounters are actually suicide attempts. Alcohol consumption is often implicated as a contributory factor in adolescent suicides."[8] Most of the reported suicide attempts in Clark County occurring January 2000-June 2001 involved drugs or alcohol (See Graph 5).

Local data for this report were collected from several emergency services sources: 911, Southwest Washington Medical Center Emergency Department, Clark County Sheriff's Office, and Clark County Crisis Mental Health Services. (Crisis mental health services are available upon request and accessed through emergency service providers, including 911, sheriff/police departments, hospital emergency department, crisis line phone numbers, and mental health service providers. Anyone is eligible for crisis mental health services, regardless of insurance coverage.) The data from the local sources reflect each of the organization's involvement in responding to youth suicide. Looked at in combination, the data provide a picture of youth suicide-related activity in Clark County from January 2000 through June 2001.

Review of local emergency services contacts from January 2000 through June 2001 revealed that 471 youth received services from sheriff /police departments, emergency department and crisis mental health services. Sheriff/police departments received calls regarding 107 youth who had attempted suicide, 12 of them more than once. The hospital emergency department saw 197 youth who had attempted suicide, with 45 youth making multiple attempts. Crisis mental health services were provided for 334 youth, of whom 53 made contact with sheriff/police departments, and 88 were seen in the hospital emergency department. Because the data are gathered in diverse ways, it was difficult to determine with certainty the overall overlap between service providers' responses to the 471 youth. Table 3 shows the number of youth seen by three of the crisis service providers: sheriff/police departments, hospital emergency department and crisis mental health services.

[8] *Adolescent Health-Volume II*, pp. 447-448.

TABLE 3.

YOUTH SUICIDE-RELATED CONTACTS JANUARY 2000-JUNE 2001	
Sheriff/Police Departments	107 total ▪ 12 multiple attempts ▪ 53 also in Crisis Mental Health Services
Hospital Emergency Department	197 total ▪ 45 multiple attempts ▪ 88 also in Crisis Mental Health Services
Crisis Mental Health Services	334 total
Total	471

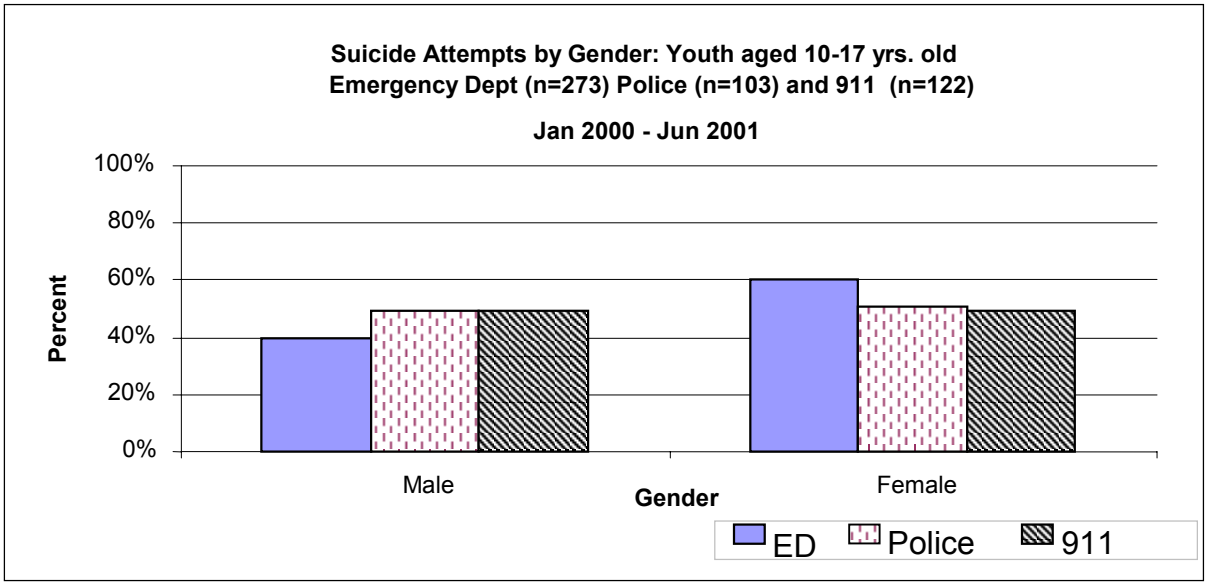
Local 911 data could not be compared with the other emergency services data due to differences in the available data from each source. There were 123 youth suicide-related calls to 911 and from January 2000 through June 2001. The calls included 46 suicide attempts and 77 suicide threats. Table 4 reflects this data.

TABLE 4.

911 YOUTH SUICIDE-RELATED CALLS JANUARY 2000 –JUNE 2001	
911	123 total ▪ 46 attempts ▪ 77 suicide threats

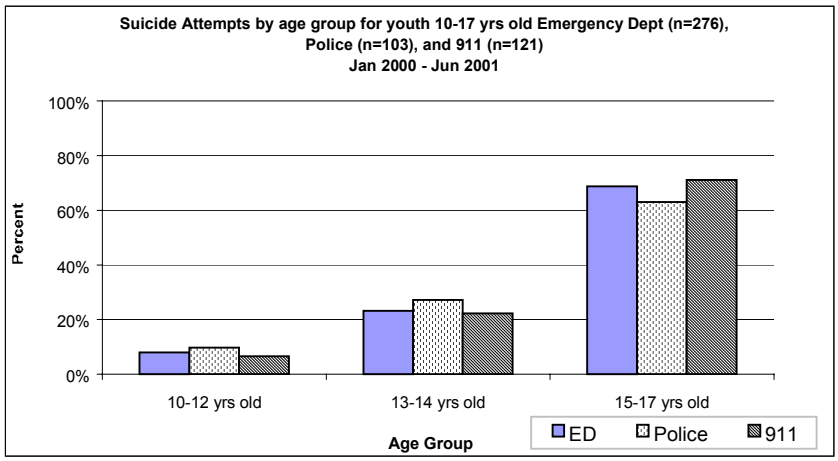
During this time period (January 2000-June 2001), more females were seen in the Emergency Department for suicide attempts or threats. (See Graph 3 below).

GRAPH 3: BY GENDER



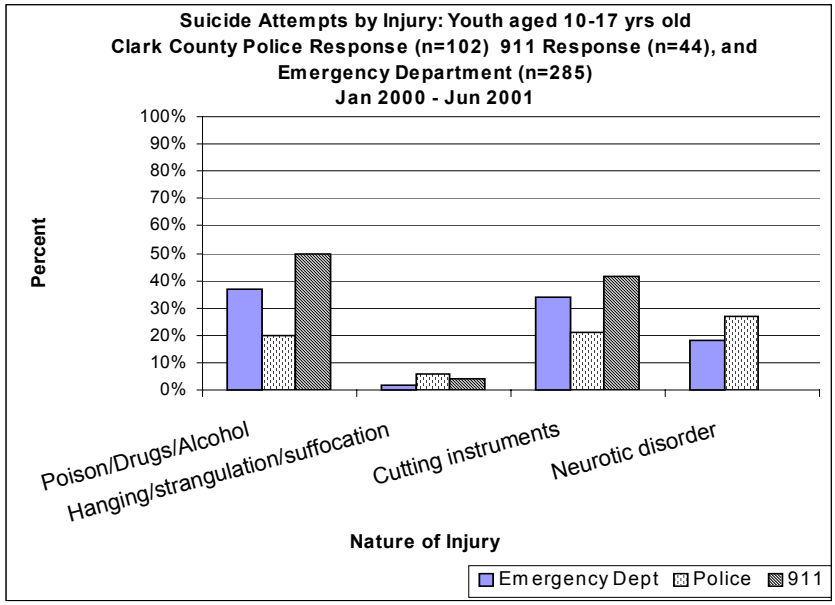
The age of Clark County youth involved in suicide attempts or threats is summarized in Graph 4 below. More than 60% of attempts in each service category were among 15-17 year olds.

GRAPH 4: AGE OF YOUTH



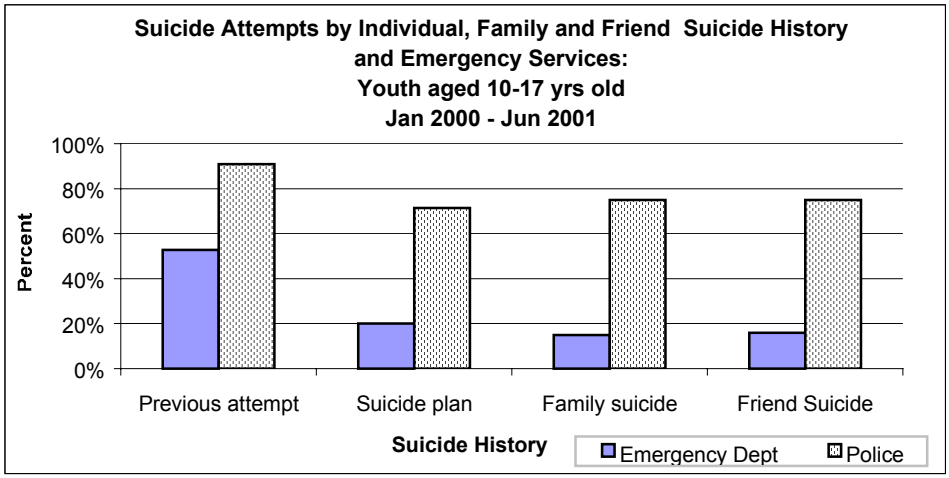
Summary data from 911, Southwest Washington Emergency Department and Clark County police response (Clark County Sheriff's Office and local police departments) regarding method of suicide attempts is shown in Graph 5. The largest number of injuries involved drugs/alcohol and cutting instruments. Also shown are attempts and/or suicide ideation involving "neurotic disorders" (e.g. states of anxiety, hysteria, depression). Attempts by firearms were very few and are not displayed.

GRAPH 5: METHOD USED/INJURY



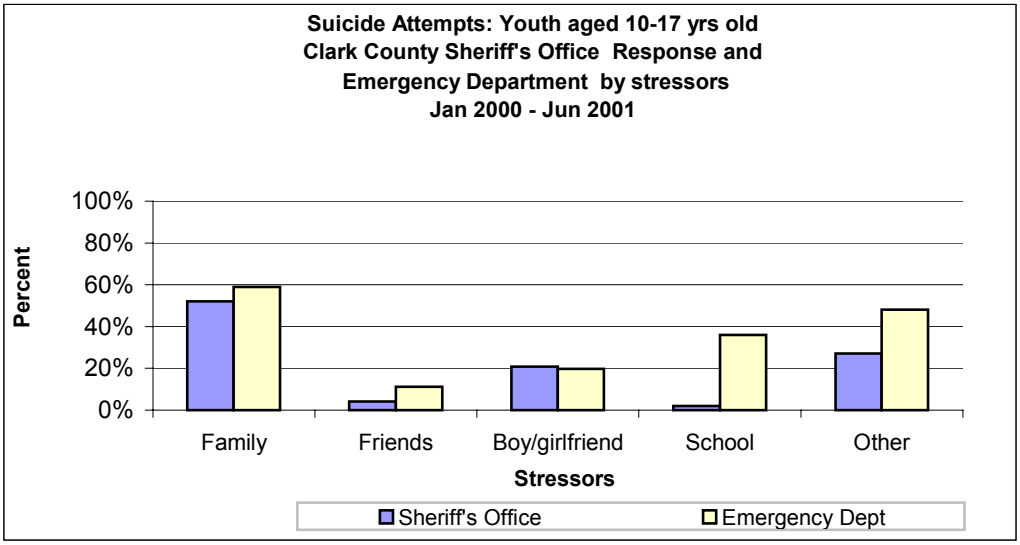
Many of the youth included in the data had a known suicide history, including previous attempts themselves, or family members or friends who had committed suicide. Graph 6 below reflects this pattern.

GRAPH 6: SUICIDE HISTORY



Youth reported various "stressors" that they believed contributed to their desire to attempt suicide. As reflected in Graph 7 below, family stressors were most frequently identified.

GRAPH 7: STRESSORS



DEVELOPMENTAL ASSETS SURVEY

A Developmental Assets Survey conducted through the Search Institute of Minneapolis, Minnesota in 1999, in combination with the data provided above, provides additional focus to the picture of youth suicide in Clark County. The survey sampled 11,795 Clark County youth in the 6th, 8th, 10th, and 12th grades to determine the degree to which Clark County youth exhibited 40 developmental assets. Youth surveyed were 52 percent male and 48 percent female.

According to the Search Institute, the optimal number of assets is between 31 and 40, with higher rates of risk-taking behavior being associated with those youth who have fewer assets. In the Clark County survey, 53 percent of youth surveyed had fewer than 20 assets. Eighty-nine percent of youth displayed 30 or fewer assets.

The 40 assets are divided into two main categories: external assets and internal assets. Together these assets provide young people with the support they need to thrive.

External assets are the support young people receive from their community. This includes support from family, friends, neighbors and school. Young people need to know that their community values them, and they need positive adult role models. They need rules for success and help in following them, and they need to have good, healthy relationships with adults in addition to their parents.

Internal assets are young people's inner strengths, including key social skills, feeling hopeful and motivated, and having compassion and integrity. These assets are important in guiding young people away from dangerous, self-destructive behaviors.

In regard to substance abuse, the Developmental Assets Survey demonstrated relatively high levels of drug and alcohol use. Forty-three percent of 12th graders reported using alcohol once or more in the last 30 days. Thirty-one percent of 12th graders reported having used alcohol three or more times in the last 30 days or getting drunk once or more in the past two weeks. Of those surveyed at all grade levels who reported having gotten drunk one or more times in the last two weeks, 63 percent had 20 or fewer assets. Twenty-four percent of 10th graders and 30 percent of 12th graders reported having used illicit drugs (e.g., cocaine, LSD, PCP or angel dust, heroin, marijuana, and amphetamines) three or more times in the past 12 months.

Table 5 describes the internal and external assets determined to be essential to effectively supporting young people.

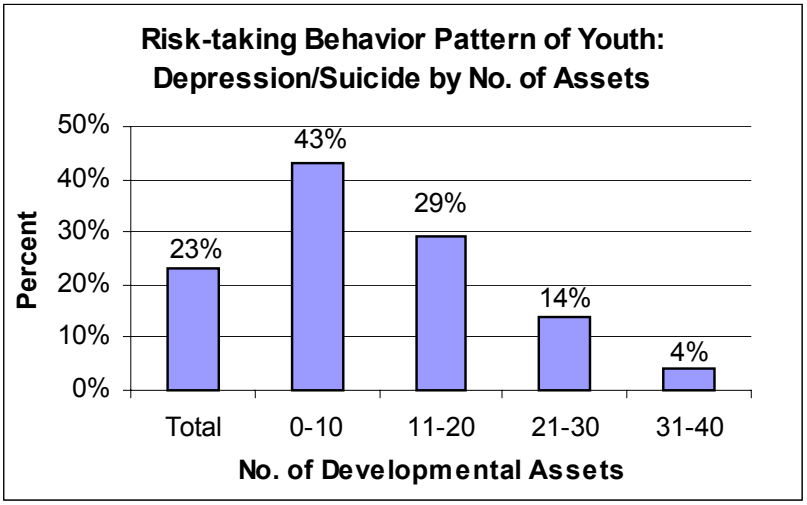
TABLE 5.

THE SEARCH INSTITUTE 40 DEVELOPMENTAL ASSETS			
CATEGORY	**EXTERNAL ASSETS**	**CATEGORY**	**INTERNAL ASSETS**
Family support	1. Family life provides high levels of love and support	**Achievement motivation**	21. Young person is motivated to do well in school
Positive family communication	2. Young person and his or her parent(s) communicate positively, and young person is willing to seek parent(s') advice and counsel	**School engagement**	22. Young person is actively engaged in learning
Other adult relationships	3. Young person receives support from three or more non-parent adults	**Homework**	23. Young person reports doing at least one hour of homework every school day
Caring neighborhood	4. Young person experiences caring neighbors	**Bonding to school**	24. Young person cares about his or her school
Caring school climate	5. School provides a caring, encouraging environment	**Reading for pleasure**	25. Young person reads for pleasure three or more hours per week
Parent involvement in schooling	6. Parent(s) are actively involved in helping young person succeed in school	**Caring**	26. Young person places high value on helping other people
Community values youth	7. Young person perceives that adults in the community value youth	**Equality and social justice**	27. Young person places high value on promoting equality and reducing hunger and poverty
Youth as resources	8. Young people are given useful roles in the community	**Integrity**	28. Young person acts on convictions and stands up for his or her beliefs
Service to others	9. Young person serves in the community one hour or more per week	**Honesty**	29. Young person tells the truth even when it is not easy
Safety	10. Young person feels safe at home, school, and in the neighborhood	**Responsibility**	30. Young person accepts and takes personal responsibility
Family boundaries	11. Family has clear rules and consequences, and monitors the young person's whereabouts	**Restraint**	31. Young person believes it is important not to be sexually active or to use alcohol or other drugs
School boundaries	12. School provides clear rules and consequences	**Planning and decision-making**	32. Young person knows how to plan ahead and make choices
Neighborhood boundaries	13. Neighbors take responsibility for monitoring young people's behavior	**Interpersonal competence**	33. Young person has empathy, sensitivity, and friendship skills
Adult role models	14. Parent(s) and other adults model positive, responsible behavior	**Cultural competence**	34. Young person has knowledge of and comfort with people of different cultural/racial/ethnic backgrounds
Positive peer influence	15. Young person's best friends model responsible behavior	**Resistance skills**	35. Young person can resist negative peer pressure and dangerous situations
High expectations	16. Both parent(s) and teachers encourage the young person to do well	**Peaceful conflict resolution**	36. Young person seeks to resolve conflict non-violently
Creative activities	17. Young person spends three or more hours per week in lessons or practices in music, theater, or other arts	**Personal power**	37. Young person feels he or she has control over "things that happen to me"
Youth programs	18. Young person spends three or more hours per week in sports, clubs, or organizations at school and/or in community organizations	**Self-esteem**	38. Young person reports having a high self-esteem
Religious community	19. Young person spends one or more hours per week in activities in a religious institution	**Sense of purpose**	39. Young person reports that "my life has a purpose"
Time at home	20. Young person is out with friends "with nothing special to do" two or fewer nights per week	**Positive view of personal future**	40. Young person is optimistic about his or her personal future

Source: Search Institute, "Developmental Assets: A Profile of Your Youth, Executive Summary," February 2000, pp. 2-3.

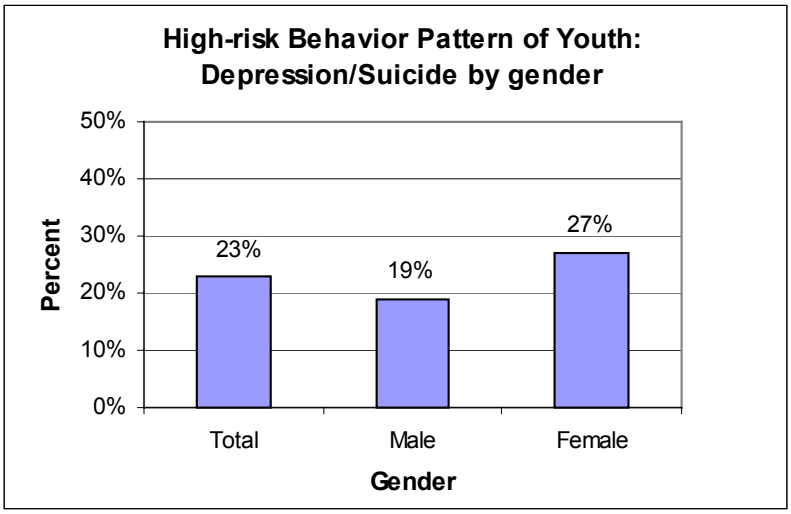
As shown in Graph 8 below, a higher percentage of young people with the lowest number of assets (0-10) report a pattern of depression and/or suicide attempts. As the number of assets increases, the percentage of youth reporting depression and/or suicide decreases substantially.

GRAPH 8: NUMBER OF DEVELOPMENTAL ASSETS



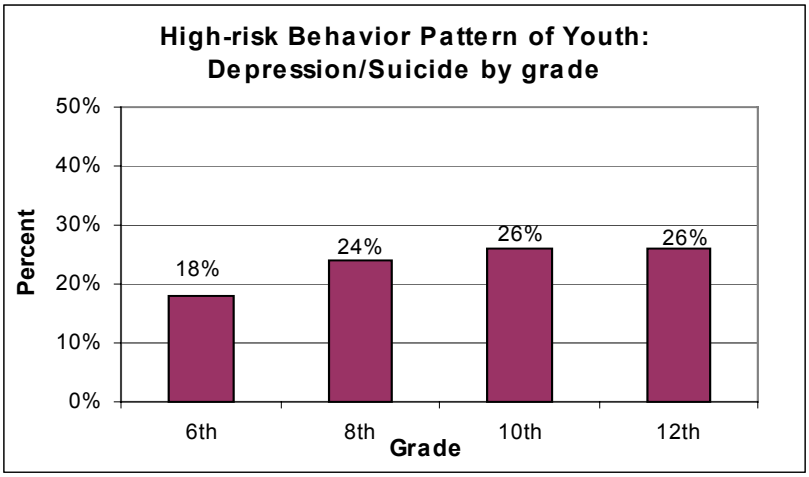
As Graph 9 indicates, females are more likely to report a pattern of depression and/or suicide attempts (27%) than males (19%).

GRAPH 9: GENDER



Graph 10 shows that young people at all grade levels surveyed reported a pattern of depression and/or suicide attempts ranging from 18-26 percent. Combined this represents over 2000 young people.

GRAPH 10: GRADE



FOCUS GROUPS

To provide a more complete picture of youth suicide in Clark County, focus groups were conducted, two with youth (total of 24 participants) and one with teachers/school personnel (11 participants), to supplement epidemiological data and data from the Developmental Assets Survey. Findings from the focus groups include the following:

- A sense of hopelessness is a common characteristic among youth.
- Youth need stronger connections with the community.
- The stigma of suicide and depression needs to be removed; the community needs to address these issues directly.
- There is a lack of resources and follow up; when a referral is made, gatekeepers want to be assured that there will be follow up.
- Available resources need to be publicized.
- Positive role models, support, and accountability are needed.
- Youth are more likely to seek help from peers than from adults.

CAPACITY MAPPING

A capacity mapping effort was implemented to assess what suicide-related resources are currently available in Clark County and to identify gaps in service and resource needs. Surveys were sent to social service agencies, healthcare organizations, schools, faith-based organizations, behavioral health agencies, special populations, and media organizations. Overall, the response rate was approximately 50 percent. Response rates were highest among schools, behavioral health, and social service agencies surveyed, while response rates were significantly lower from healthcare organizations, media, and faith-based organizations.

Capacity mapping efforts revealed a particular need for the implementation of universal strategies (e.g., public education, school-based prevention campaigns) and increased capacity in regard to targeted strategies.

For example, while gatekeeper training is available, it is underutilized in Clark County. Expanded availability of training opportunities is needed. Likewise, crisis intervention services are available, but issues relating to eligibility and insurance coverage limit access. There is also a need to improve and coordinate evaluation and data to better understand service needs and the dynamics of youth suicide in Clark County.

Updating the capacity mapping data will be an ongoing effort by organizations collaborating on implementing this plan.

TABLE 6.

CAPACITY MAPPING SUMMARY

Competent Community Resources	Clark County Resources	Washington State Youth Suicide Prevention Program Resources
Universal Strategies		
County-wide public education campaign on suicide prevention	Unavailable	Resources Available
School-based education campaign for youth and parents	Limited Availability	Resources Available
Public education campaign to restrict access to lethal means of suicide	None Identified	None Identified
Education on media guidelines	None Identified	References Available
Targeted Strategies		
Screening programs for youth	Available	None Identified
Gatekeeper training	Limited Availability	Training Available
Community-based crisis intervention	Limited Accessibility	Hot Lines Available
Intensive Strategies		
Support/skill-building groups	Available But Inconsistent	None Identified
Family support training	Available Primarily Through Social Services	None Identified
Evaluation and Data Tracking		
Program evaluation of universal, targeted, and intensive strategies	Available But Not Comprehensive	Established
Surveillance	Limited	None Identified*

* Assessment is based on a comparison with the Competent Community Resources listed in the left-handed column. More detailed information provided in Appendix A.

Figure A-1

UNIVERSAL STRATEGIES

Competent Community	Clark County	Washington State Youth Suicide Prevention Program
Resources	*Resources*	*Resources*
County-wide public education campaign on suicide prevention • *Campaign to help general public, youth, and parents become aware of youth suicide and suicidal behaviors, to recognize warning signs, to learn how to respond, and to know when and where to seek professional help.*	• Youth Suicide awareness evening being planned by Family of Christ Lutheran Church. • Children's Home Society offers parent education classes (which have a component on suicide) for parents of youth ages 10-16. • First Presbyterian Church of Vancouver offers Stephen Ministries training that includes recognizing those who might be suicidal and dealing with the aftermath of suicide. • St. Joseph Catholic Church covers youth suicide in their "Life Issues" presentations at least twice per year.	• Youth Suicide Prevention Program web site. • Youth suicide prevention and response literature, resources, and materials. • Technical assistance.
School-based education campaign for youth and parents • *Education programs in middle schools, high schools, and colleges to teach youth and their parents about the warning signs of suicidal intent and to help youth access prevention services.*	• Youth suicide information through health education classes at Gaiser Middle School and Jason Lee Middle School. • Suicide unit taught by school counselor at Legacy High School. • Educational services offered through Columbia River Mental Health. • Information distributed to parents of McLoughlin Middle School regarding warning signs and community resources. • Suicide awareness assembly provided to high school and middle school students in Battle Ground School District. • The counseling department at Heritage High School provides information to every student on the subject of suicide and how to respond. A "Resources for Teens 2000" pamphlet is also given to every student. • Youth suicide information through health education classes, yearly training for all students starting 2001-2002 school year, student anti-violence education club 9/99, peer mediation 9/99 at Hudson's Bay High School.	• Toolkit for schools. • Sample posters, T-shirts, buttons, etc. for student campaigns. • Training sessions for students. • Technical assistance.

(Universal Strategies, continued)

Competent Community	Clark County	Washington State Youth Suicide Prevention Program
Resources	*Resources*	*Resources*
	• Washington State School for the Blind invited a speaker to address the issue of youth suicide. • Guidance counselors provide information about youth suicide in the classrooms. • The Evergreen School District offers some prevention education in groups and classrooms at various secondary schools. Also counselors have information and web sites that can give students information on suicide prevention and resources. • Columbia River High School covers youth suicide in health education curriculum.	
Public education campaign to restrict access to lethal means of suicide • *Effort to reduce access to firearms and other lethal means of suicide, particularly in homes with at-risk youth.*	*None identified*	*None identified*
Education on media guidelines • *Program to educate media in reporting and interviewing practices that reduce the likelihood of "contagion effects" following suicide.*	*None identified*	References to media guidelines developed by national youth suicide prevention organizations. Technical assistance.

TARGETED STRATEGIES

Competent Community	Clark County	Washington State Youth Suicide Prevention Program
Resources	*Resources*	*Resources*
Screening programs for youth • *Identify high-risk youth who show early signs of suicide risk, assess level of risk, and refer to needed prevention or crisis services.*	• Depression screenings offered through Columbia River Mental Health. • Referral services for at-risk youth (primarily to mental health system) available through a number of organizations including Clark County Council on Alcohol and Drugs, Juvenile Court, SWMC-Hospice Program, Parent	*None identified*

(Targeted Strategies, continued)

Competent Community	Clark County	Washington State Youth Suicide Prevention Program
Resources	*Resources*	*Resources*
	Child Health-SWWHD (if Medicaid eligible; pregnant or postpartum), Janus Youth Programs, A.A., Sheriff, YWCA, Free Clinic of SWW, Daybreak, and Division of Children and Family Services. • Mental health screenings in Vancouver School District for middle school students, and by Juvenile Court. • Assessment and referrals provided by Jason Lee Middle School, Gaiser Middle School, McLoughlin Middle School, Camas High School, Legacy High School, Vancouver Community Christian School, Hockinson Middle School, Discovery Middle School, Skyview High School, Hudson's Bay High School, Washington School for the Deaf, Evergreen School District, Columbia River High School, Battle Ground School District, Crossroads Community Church, St. Joseph Catholic Church, Immanuel Lutheran Church, Family of Christ Lutheran Church, Elim Evangelical Lutheran Church, and Meadow Glade School. • Youth Pastor at First Presbyterian Church of Vancouver worked with the youth in the church and dealt with issues related to suicide and the loss of friends.	
Gatekeeper training • *Provide adults working with high-risk populations (e.g., teachers and school personnel, physicians, emergency room personnel, mental health and substance abuse specialists, clergy, juvenile justice personnel, etc.) with information about effective screening and intervention strategies.*	• Training for school counselors available following a youth suicide provided through SWMC-Hospice Program. • Bible studies and discussion groups for youth who have had classmates commit suicide provided by Family of Christ Lutheran Church. • Question, Persuade, Refer training (two-hour youth suicide prevention training) offered by Sheriff and Juvenile Court to Juvenile Detention Officers and youth in detention center.	• Two-day training sessions in suicide prevention provided by Living Works-certified trainers (Living Works is widely regarded as a leading training program in youth suicide prevention).

(Targeted Strategies, continued)

Competent Community	Clark County	Washington State Youth Suicide Prevention Program
Resources	*Resources*	*Resources*
• *Provide youth peers with knowledge and skills to recognize risk factors, communicate with their peers, and help connect their peers to needed services.*	• Ongoing mentoring program for young women through YWCA. • Two intervention specialists in Battle Ground School District work with students who have friends exhibiting suicidal tendencies. • Staff crisis management training 9/00, staff Question, Persuade, Refer training 9/01, and Gatekeeper training 12/00 at Hudson's Bay High School.	
Community-based Crisis Intervention • *Services to assist at-risk youth, including crisis hotlines, mental health services, substance abuse services, etc.*	• In-house mental health services for the general population and at-risk youth through the Juvenile Detention Center, Clark College, and the Cancer Center. • Outpatient mental health services for low-income youth through Children's Center. • Crisis intervention for youth and families provided by mental health providers, including Columbia River Mental Health, Multiple Crisis Assignment Team, and Catholic Community Services. • Crisis lines: (360) 696-9560 or (800) 626-8137. • School counselors available at Jason Lee Middle School, Discovery Middle School, McLoughlin Middle School, Camas High School, Legacy High School, Vancouver Community Christian School, and Meadow Glade School. • Counseling services available through SWMC-Hospice Program, Parent Child Health-SWWHD (if Medicaid eligible; pregnant or postpartum). • Pastoral counseling offered through Family of Christ Lutheran Church.	• Teen Link Crisis Line: (888) 431-8336 • National Youth Crisis Line: (800) 784-2433 (1-800-SUICIDE)

INTENSIVE STRATEGIES

Competent Community	Clark County	Washington State Youth Suicide Prevention Program
Resources	*Resources*	*Resources*
Support/skill-building groups • *Provide high-risk youth with opportunities to strengthen their support network, learn life-skills in mood management, decision-making, help-seeking, and communication, and decrease risk factors.*	• Two intervention specialists in Battle Ground School District work with youth with suicidal tendencies. • Children's Home Society provides treatment for youth who have attempted or threatened suicide. • Peace Health Recovery Northwest provides support services to youth and their families. • Ongoing support through the transition period offered by the Evergreen School District. • Vancouver School District's counseling staff usually monitors the student and provides ongoing support and responsive services. Also there are guidance activities, individual/group counseling and crisis intervention. • Camas High School provides ongoing counseling. • Ongoing support provided by Elim Evangelical Lutheran Church, Family of Christ Lutheran Church, and Immanuel Lutheran Church.	*None identified*
Family support training • *Training to reinforce skill-building training provided to youth; increases family support skills for high-risk youth.*	• Survivor outreach and trauma debriefing offered through Columbia River Mental Health. • Family team building for youth with mental health issues and their families offered through Catholic Community Services. • Division of Children and Family Services provides out-of-home and in-home crisis counseling services. • Bereavement and loss groups offered through Hudson's Bay High School.	*None identified*

EVALUATION AND DATA TRACKING

Competent Community	Clark County	Washington State Youth Suicide Prevention Program
Resources	*Resources*	*Resources*
Program evaluation of universal, targeted, and intensive strategies • *Process evaluation to assess implementation and outcome evaluation and efficacy of prevention strategies in decreasing youth suicide and suicidal behaviors.*	• Evaluation of training program for school counselors available following a youth suicide (significant findings unknown). • Evaluation of counseling and referral services offered through the SWWMC-Hospice Program (significant findings unknown). • Evaluation of suicide awareness program offered through Battle Ground School District (significant findings unknown). • Evaluation of outpatient mental health services offered through Children's Center (significant findings unknown). • Evaluation of crisis intervention services offered through Multiple Crisis Assignment Team and Columbia River Mental Health (significant findings unknown).	• 1999 evaluation of the implementation of the Washington State Youth Suicide Prevention Program. • 2000 evaluation focusing on school-based intervention programs implemented by the Washington State Youth Suicide Prevention Program.
Surveillance • *Monitoring of completed suicides, suicide attempts, and other suicidal behaviors.*	• Child Death Review • 911 Data • Coroner's Data	*None identified*

APPENDIX B: EVALUATION AND DATA MONITORING

Strategy	Outcomes	Indicators
1. Educate the public about youth suicide.	Increased community awareness of suicide warning signs.	Percent of ▪ parents ▪ school personnel ▪ students ▪ community members who report knowledge of youth depression and suicide warning signs.
	Increased community awareness of risk and protective factors.	Percent of ▪ parents ▪ school personnel ▪ students ▪ community members who report knowledge of risk and protective factors.
	Increased community awareness of available youth suicide-related resources.	Percent of ▪ parents ▪ school personnel ▪ students ▪ community members who report knowledge of available youth suicide-related resources.
	Increased community competence in taking the three recommended prevention steps: ask the question, show you care, refer to resources.	Percent of ▪ parents ▪ school personnel ▪ students ▪ community members who report familiarity with and ability to use the three recommended prevention steps.
2. Establish media partnerships.	Local media abide by the Centers for Disease Control reporting guidelines in youth suicide coverage.	Percent of media organizations that participate in youth suicide prevention training opportunities. Percent of media organizations that comply with the Centers for Disease Control guidelines when reporting on youth suicide. Percent of middle and high schools that have a response system in place for students in the event of a suicide.

(Evaluation and Data Monitoring, continued)

Strategy	Outcomes	Indicators
	Local media assist the community in preventing youth suicide by publicizing known prevention strategies and/or prevention-related events.	Percent of media organizations that sponsor public service announcements dealing with youth suicide prevention.
3. Develop peer resources through school-based prevention campaigns.	All school districts in Clark County endorse and adopt a standardized youth suicide prevention program.	Percent of schools that have endorsed and adopted a standardized youth suicide prevention program.
4. Develop active community involvement in positive youth development.	Increased community awareness of suicide risk and protective factors.	Percent of ▪ parents ▪ school personnel ▪ students ▪ community members who report knowledge of risk and protective factors.
	Increased community awareness of ways to support positive youth development. Increased community awareness of ways to support positive youth development.	Percent of ▪ parents ▪ school personnel ▪ community members who report knowledge of ways to support positive youth development. Percent of community members involved in mentoring programs and/or other programs linking adults and youth. Results of future Developmental Assets surveys.
5. Conduct suicide prevention and intervention training for professionals and others who work with youth.	Increased ability of professionals and others who work with youth to intervene appropriately with at-risk youth.	Percent of professionals and others who work with youth who endorse and practice recommendations of "gatekeeper" training. Percent of youth who report satisfaction with services and/or support received from professionals and others who work with youth.

(Evaluation and Data Monitoring, continued)

Strategy	Outcomes	Indicators
6. Improve access to mental health and substance abuse intervention and treatment services.	Increased number of youth who receive mental health and substance abuse services.	Number of youth who receive mental health and substance abuse services.
	Improve the timeliness of the mental health and substance abuse services provided to youth.	Number of months an individual must wait to obtain services. Number and percent of youth who are placed on waiting lists for services. Number and percent of youth who receive preventive vs. crisis services.
	Improve the appropriateness of the mental health and substance abuse services provided.	Number and percent of youth who receive: ▪ all of the mental health and substance abuse services called for by a clinical assessment. ▪ the duration of mental health and substance abuse services called for by a clinical assessment . ▪ mental health and substance abuse services they view as culturally appropriate.